STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155093	A. BUILDING _____ B. WING _____	02/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIBSON GENERAL HOSPITAL-SNF	1808 SHERMAN DRIVE PRINCETON, IN 47670

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey. Survey dates: January 31-February 3, 2011 Facility number: 000036 Provider number: 155093 AIM number: 100269640 Survey team: Sue Webster, RN,TC Diane Hancock, RN Jodi Meyer, RN Guylene Maurer, RN, 1/31-2/1, 2/3, 2011 Census bed type: SNF/NF: 41 Total: 41 Census by payor type: Medicare: 8 Medicaid: 25 Other: 8 Total: 41 Sample: 11 Supplemental sample: 13 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review 2/10/11 by Suzanne Williams, RN	F 000	Submission of this plan of correction shall not be constitute or be construed as an admission by this facility that the allegations in this survey report are accurate or reflect accurately the provision of nursing care and service to the residents of Gibson General Hospital SNF. This facility requests the following plan of correction be considered its allegation of compliance. RECEIVED FEB 24 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marsha K. Richardson	HFA	2/23/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 253	Continued From page 1	F 253		

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to ensure housekeeping and maintenance services were provided to maintain a sanitary, orderly and comfortable interior, for 4 of 8 sampled resident rooms, in that floors were soiled, paint was missing, faucets had a build-up of substances, and doors were marred/gouged. This had the potential to affect 8 residents residing in the rooms. (Rooms 5531, 5515, 5581, 5517)

Findings include:

1. On 2/1/11 at 1:15 p.m., the following was observed in room 5531:
The floor tiles around the edges and in the corners of the room were soiled with loose dirt and discolored gray. The bathroom had a urine odor.

2. On 2/1/11 at 1:25 p.m., the following was observed in room 5515:
The floor tiles around the edges and in the corners of the room were soiled with loose dirt and discolored gray.

3. On 2/3/11 at 10:15 a.m., the following was observed in room 5581:
The floor at the entrance to the bathroom had a gray stain on the floor tiles along the edges of the room. The bathroom sink had a build up of white substance on the faucet. The four drawers of the cabinet and the frame, beside the room sink, had bare wood exposed due to missing/chipped paint. The area of the ceiling, over the room sink, had a

F 253

What corrective action will be accomplished for those residents found to have been affected by the deficient practice?

1. Floor tiles in rooms 5531, 5515, 5581, and 5517 have been inspected, all discolored gray areas have been addressed by stripping down the wax layer,cleaning, and thereby preparing those floors for a new coat of wax.
2. Rooms 5515, 5531, and 5517 have had attention to remove any loose dirt noted during survey.
3. Rooms 5581 and 5517 have had missing/chipped paint sanded and repainted.
4. Rooms 5581 and 5517 have had the buildup of the white substance removed.
5. Ceiling areas have been patched/repaired in room 5581.
6. Bathroom door gouge in 5517 has been repaired.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?

1. All resident rooms have been assessed for discolored tile and the specific need for stripping and waxing. A plan has been developed to strip and wax each room that has not already been stripped and waxed, leaving **10** rooms remaining as of 2/25/11. The plan calls for 2 rooms per week, three when possible, based on our residents' conditions at that time. **The plan will finalized by Feb. 25, systemic changes to the plan will be completed by March 5,** but will take approximately 5 additional weeks to complete the entire facility with all rooms being stripped and waxed by April 1, 2011. Attachment _____.
2. All resident rooms have been inspected for any build up of loose dirt, dust. All floors have been dusted to remove any loose dust. The floor product representative has been contacted and has completed an onsite inspection of the facility floors, methods of product use for proper application of products and continued proper maintenance.
3. Each resident room has had paint touch up on painted doors and drawers.
4. Remaining affected bathroom doors have been identified and product ordered for placement/repair by March 5, 2011.

F 253

What measures will be put into place to ensure that the practice does not recur?

1. Facility service employees have been made aware of findings and the requirements necessary to be in compliance with F253 and the expectations of Gibson General Hospital SNF for the residents' sanitary, orderly, and comfortable interior.
2. Facility services will be inserviced on Feb. 22 by the representative of our floor care products for proper use and maintenance.
3. Once all floors have been stripped and waxed, the re-waxing schedule will begin again and continue throughout the year.
4. Hallways will be dusted and wet pad mopped daily.
5. Rooms will be dusted and pad mopped daily.
6. Hallways will be additionally buffed 3x weekly.
7. Inservice presented by the product representative will be taped for future training needs for any new employee.

How the corrective action will be monitored to ensure the deficient practice will not recur?

The facility services director or his designee will randomly monitor 5 resident rooms weekly for sanitary, orderly, and comfortable interiors with findings reported to the Performance Improvement Committee quarterly. Attachment I + J.

Systemic changes will be completed by March 5, 2011.

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F 253	Continued From page 2 circular area of exposed cement with a round hole in the center. Housekeeper #1 was queried at this time about the discolored areas on the tile. She indicated she didn't know what it was and that it wouldn't come up. 4. On 2/3/11 at 2:07 p.m., the following was observed in room 5517: The floor tiles of the room were discolored gray around the edges of the room. There was loose dirt behind the room door and in the corner under the bathroom sink. The bathroom sink had a build up of white substance on the faucet. The bathroom door was gouged with exposed, unfinished wood. 3.1-19(f)	F 253		3/5/11
F 256 SS=E	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure adequate and comfortable lighting levels were provided in the bathrooms, for 6 of 8 sampled resident rooms, in that lighting was low around the sink and toilet areas where care would be provided. This had the potential to affect 12 residents. (Rooms 5531, 5515, 5581, 5517, 5537, 5535) Findings include: 1. On 2/1/11, the light in the following residents' rooms were as follows:			

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F 256	Continued From page 3			

Room 5531 at 1:15 p.m., the light measured ten Foot-Candles at the bathroom sink level and less than ten at the toilet.

Room 5515 at 1:22 p.m., the light measured ten Foot-Candles at the bathroom sink level and less than ten at the toilet.

Room 5537 at 1:25 p.m., the light measured 15 Foot-Candles at the bathroom sink level and less than ten at the toilet.

On 2/3/11, the light in the following residents' rooms were as follows:

Room 5535 at 1:00 p.m., the light measured 15 Foot-Candles at the bathroom sink level and less than ten at the toilet.

Room 5581 at 1:05 p.m., the light measured ten Foot-Candles at the bathroom sink lever and less than ten at the toilet.

Room 5517 at 2:01 p.m., the light measured ten Foot-Candles at the bathroom sink lever and less than ten at the toilet.

2. On 2/3/11 at 2:45 p.m., the facility Administrator was apprised of the above observations. The Administrator contacted the maintenance supervisor to review the observations. The above rooms were rechecked by the Director of Environmental Services [DES] with his light meter and registered the same.

In room 5517, the DES removed the cover from the bathroom light fixture. The fixture held a single energy efficient bulb. The DES indicated

F 256

What corrective action will be accomplished for those affected by the deficient practice?

1. All room listed, 5531, 5515, 5537, 5535, 5581, and 5517 have had 95 watt incandescent lamp which provides the required minimum of 20 Foot candles per sq. foot.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?

1. All resident rooms were assessed for lighting in the bathrooms.
2. All resident bathrooms have had the bulbs replaced with 95 watt incandescent bulbs to provide the required minimum of 20 Foot candles per sq. foot.

What measure will be put into place or what systemic changes will be made to ensure the practice does not recur?

1. All facility service staff has been educated by the facility services manager to replace light bulbs in SNF bathrooms with only 95 watt incandescent bulbs.
2. Additional light bulbs will be stored in the nursing station for replacement as needed in the night when facility services staff are not available.

How will the corrective action be monitored to ensure that practice will not recur?

Facility services director or his designee will randomly monitor 5 rooms weekly for working, proper sized bulbs in bathroom fixtures and will report to Performance Improvement Committee quarterly. Attachment I + J.

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F 256	Continued From page 4 he was surprised that there was only one light fixture in the bathroom. He indicated that the light bulb used in the past may have been an incandescent bulb that was brighter.	F 256	Systemic changes will be completed by March 5, 2011.	
F 272 SS=D	3.1-19(dd) 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.	F 272	What corrective action will be accomplished for those affected by the deficient practice? For Resident #19: 1. MDS Coordinator did, in fact, meet with the Hospice nurse and stressed the importance of being notified of any new areas that she may find. She explained our process of documentation and how we are obligated to follow through for the resident , care planning, documentation on established forms, and hospice assured her this would occur in the future. Nursing staff was made aware of how this 1 resident, # 19, did not have the proper documentation on the established forms which would have alerted MDS Coordinator prior to resident going on hospice and would've enabled knowledge of the open area at an earlier date. When last assessed in December, her wound was healed. Rounds are completed weekly on those with open areas, and measurements obtained.	

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F 272	Continued From page 5	F 272		

This REQUIREMENT is not met as evidenced by:
Based on record review, observation and interview, the facility failed to comprehensively assess 1 of 7 sampled residents at risk for pressure sores, and 1 of 1 sampled resident with seat belts, in the total sample of 11, in that pressure ulcers were not assessed upon developing, and a resident was not assessed for the use of self release belts. (Residents #19, #9)

Findings include:

1. During the initial tour of the facility, on 1/31/11 at 11:35 a.m., RN #2 indicated Resident #19 was recently admitted to hospice care. She indicated she had weight loss, incontinent of bowel and bladder, multiple sclerosis, diabetes mellitus, and a new diagnosis of cancer.

The clinical record was reviewed on 2/1/11 at 2:20 p.m. The physician had given a telephone order on 1/18/11 for a treatment change to the coccyx, "Discontinue Allevyn dressing to coccyx. Mepilex border dressing 4 X 5 cm [centimeters] square apply to coccyx after cleaning with wound cleanser. Do tx [treatment] Tuesday, Saturday and prn." The original treatment of Allevyn was ordered 12/17/10.
The medical record did not record any other information regarding the coccyx area.

The Hospice medical record was reviewed on 2/1/11 at 2:30 p.m. The resident was admitted to hospice on 1/12/11. The open area was first described on 1/17/11 by the hospice nurse, 0.1 X 0.2 X <0.1, no exudate, no odor and no inflammation. The hospice documented the area

2. MDS error of 1/20/11 has had a correction submitted to indicate the area at the time of the assessment. 2/4/11

3. Facility has tried a low air loss mattress for this resident and she tolerated it for a very short time and requested that it be removed. She is very particular about her likes and dislikes and also often refused to be turned and/or be repositioned. The record has this documentation but is not continually repeated. Her preferences have now been specifically indicated in the chart and on her care plan. Staff has talked with her about the risks not turning frequently, not allowing heels to be floated, and other such choices she makes that could involve risks. She has verbalized understanding and this has been documented.

4. The resident was at that time placed on the wound round list for weekly assessment of her open area/areas. Will be maintained on this list for continual follow up until healed, then be assessed weekly with full body assessment.

3/5/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 272	Continued From page 6	F 272		3/5/11

to the coccyx additionally on 1/24/11 0.3 X 0.2 X <0.1 and 1/31/11 0.3 X 0.4 X <0.1. Each measurement was larger than the last.

The "Norton Pressure Sore Risk Assessment" was completed on 1/12/11. The total score was 10; the score of 10-13 placed the resident at High Risk.

RN #3 was interviewed on 2/2/11 at 11:15 a.m. She was identified by the Administrator as the person in charge of the pressure ulcer/wound team. She indicated the resident did not have a pressure ulcer currently and presented a form which recorded a healed wound from December 2010. No other pressure ulcer records were available for the current wound being treated.

RN #3 indicated that she made skin rounds every Tuesday and the resident had not been seen during the rounds since December 2010.

Resident #19's area was observed, on 2/2/11 at 11:20 a.m., with RN #4. The resident was positioned on her back with bilateral heels on the mattress with a small pillow between the feet. The resident was turned to her side, she was lying on a square waffle air cushion under her buttock area. The foam dressing was pulled to the side by RN #4. Two small areas at the coccyx area were observed. The skin around the open areas was dark pink in color. RN #4 indicated the resident had two areas to the coccyx. The foam dressing was replaced.

Prior to leaving the room, RN # 3 who was in charge of wound rounds and MDS assessments, entered the room. She asked RN #4 if the resident had open areas; RN #4

5. Hospice and a granddaughter convinced resident to try low air loss mattress again. Resident agreed with much hesitation and on 2/11/11, she insisted the mattress be removed and her Panacea Clinical mattress placed back on her bed. She also insists that a pillow be between her feet and that they not be floated. These preferences have been Care Planned and noted in her clinical record, after explaining the risks.

6. Resident will have a full body assessment weekly by the nurse. (NEW). Attachment A.

<u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</u>

All residents have been assessed with their care and have received a full body assessment within the past week by their nurse. Any areas found were to be documented according to policy. None were found.

2/20/11

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F 272	Continued From page 7	F 272		

answered in the affirmative. RN #3 indicated she was unaware of the areas.

On 2/2/11 at 2:05 p.m., RN #3 indicated she had sent word to the hospice nurse to report to her if she found open areas on residents again. She indicated the resident had requested the waffle type cushion and that an low air loss mattress had been tried, and the resident had requested it be removed. RN # 3 indicated she was unaware of what type of mattress the resident was currently using on 2/2/11.

At 2:15 p.m. on 2/2/11, CNA #1 removed the sheet off the mattress to display the name of the mattress "Panacea Clinical." At 2:35 p.m. the Administrator received information online regarding what type of mattress the resident was using, indicating it was a pressure reducing mattress.

The MDS [Minimum Data Set] quarterly assessment, dated 12/23/10, recorded the resident was "At Risk for developing pressure ulcers." The resident was identified as having an unhealed pressure ulcer, Stage 2, described as "Necrotic tissue (Eschar)." Interventions included on the assessment were "Skin and ulcer treatments application of nonsurgical dressings and applications of ointments/medications other than feet."

The newest MDS change of condition assessment, dated 1/20/11, recorded the resident was at risk for pressure ulcers, 0 [zero] current pressure ulcers, and no pressure ulcers present on the prior assessment.
"Skin and ulcer treatments" indicated "applications of ointments/medications other than

F 272

What measures will be put into place or what systemic changes will be made to ensure that the practice does not recur?

1. A schedule has been developed to assess each resident's body weekly by the nurse.
   Attachment B1 and B2
2. The completed assessments will be in the record for reference.
3. Assessment completion will be documented on the treatment sheet weekly.
4. Inservice held 2/10/11 + again 2/25/11 (for handwashing, decub prevention, infection control

How will the corrective action be monitored to ensure the practice will not recur?

Random body assessments will be monitored for completion by the DON or the designee during the random weekly chart audit that we are currently performing on a minimum of 5 charts. Any areas found on the assessments will be reviewed for proper documentation on established forms and proper follow through. Will report findings at the quarterly Performance Improvement Committee mtg.
Attachment C + C1

Systemic changes will be completed by March 5, 2011.

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F 272	Continued From page 8			

to the feet."
The Braden Pressure ulcer assessment tool was dated 12/23/10 and 1/20/11; both recorded the total as 15. The form recorded "At Risk" 15-18.

The MDS Skin and Ulcer treatment area included "pressure reducing device for chair, pressuring reducing device for bed, turning/reposition program, nutrition or hydration intervention to mange skin problems, and ulcer care." None of those areas were marked for the resident in either assessment.

On 2/3/11 at 10:30 a.m., the Administrator, Director of Nurses and RN #3 discussed the above resident's care. RN #3 indicated the resident did not a have daily skin observation sheet or record on the skin assessment action sheet for the above open areas.

RN #3 indicated she reviewed the clinical records when completing the MDS assessments, "I just missed that...." She indicated the MDS assessment was coded wrong.
2. During the initial tour, on 1/31/11 at 11:52 a.m., RN #2 indicated Resident #9 had fallen at home and had a subdural hematoma. A craniotomy had been done a couple weeks ago and found old blood and new blood. She indicated the resident was using easy release seat belts in the chair, a floor mat alarm, pad alarms, a low bed, and a roll belt in bed. She indicated the resident had not had any falls at the facility.

Resident #9's clinical record was reviewed on 2/1/11 at 10:15 a.m. The resident was admitted to the facility on 11/15/10 with diagnoses including, but not limited to, acute and chronic

3/5/11

F 272 Resident # 9:

What corrective action will be accomplished for those affected by the deficient practice?

1. Resident #9 was assessed 2/2/11 for continued use of current safety devices. Was able to demonstrate, as indicated by surveyor, that she was able to remove waist EZ release belts. Assessment at that time did include the 2nd belt. Surveyor did indicate that after much thought regarding this resident, she certainly could understand our concern for her safety. Her craniotomy was only 2 weeks prior, incision line still healing, bleeds had been the issue, and the resident was indeed at risk for falls. Although conversations and assessments had occurred in that we had assessed her need for the extra safety precautions and actual conversations that we had held with therapy regarding her safety, her ability or lack thereof to be up in the room, or her apparent need for additional safety interventions at this time, it was not documented on the physical assessment restraint reduction sheet.

2. Has been re-assessed at this time and we have been able to reduce her interventions by removing the second belt and she has had no falls.

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F 272	Continued From page 9	F 272		

subdural hematoma, dementia, fibromyalgia, reflux, hyperlipidemia, hypertension, arthritis, and Alzheimer's Disease. The resident was readmitted to the facility on 1/21/11, following a craniotomy to clear out the hematoma. The resident's fall risk assessment, on 11/18/10, indicated she was at high risk for falling (score of 19, with 10 or greater being high risk). The fall assessment on 1/21/11 indicated the resident was at high risk for falling, with a score of 13.

Resident #9 was observed on 1/31/11 at 3:05 p.m. She was seated in her recliner chair with a self-release alarming seat belt on, and a blue padded belt on, with a velcro release. On 2/1/11 at 12:50 p.m., the resident was seated in her recliner chair with an alarming seat belt and the soft belt with a velcro release.

RN #2 provided a "Daily Alarm Worksheet" on 1/31/11 at 12:03 p.m. The worksheet indicated the following interventions for Resident #9:
HiLo bed with floor mat
Roll belt in bed and clip alarm
Easy release alarming belt in chair and wheelchair
May release if family present
Mat alarm in front of bed or chair
Pad alarm in recliner
2nd blue EZ release belt in the recliner
Cushion lap belt while in W/C [wheelchair]

LPN #1 [Resident #9's Power of Attorney], the nurse on the unit, and RN #3 [Assessment Nurse] were interviewed, on 2/1/11 at 2:40 p.m. RN #3 indicated the resident could release both belts. LPN #1 indicated she didn't ask the resident to release the belts because she wanted her to leave them on. Both indicated the reason for the

3. We have increased her activity as tolerated to provide extra stimulation to promote better rest, and she is currently on a Restorative program for ambulation.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?

1. All residents with device interventions for safety have been reviewed for assessments indicating their need.

2. Residents with devices that are self releasing have demonstrated their ability to release the device and this assessment has been documented.

3. Inservices 2/10/11 & 2/25/11.

What measures will be put into place or what systemic changes will be made to ensure that the practice does not recur?

Quarterly Physical Restraint Assessment will note those involved in resident assessment, including PT if indicated, and will note the decision regarding any self releasing device.

3/5/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155093	A. BUILDING _____ B. WING _____	02/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIBSON GENERAL HOSPITAL-SNF	1808 SHERMAN DRIVE PRINCETON, IN 47670

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 10	F 272		

two belts was to give staff more time to get to her if she was getting up.

The Administrator and Director of Nurses [DON] were interviewed on 2/2/11 at 2:00 p.m. Both indicated it was decided to use two belts because the resident was very fast; one alarm would sound and it gave staff enough time to get to her before the other belt was released. Both indicated they were unaware if the therapy department had been involved in assessing the resident for the use of the seat belts or positioning for safety. They both indicated they would like the resident to be up ad lib, staff would walk with the resident when she got anxious, the resident would not wear a helmet for protection if fell, and it had only been two weeks since craniotomy.

The Physical Restraint Elimination Assessment was reviewed. On 11/18/10, the assessment indicated, "Release restraint when with family. Needs roll belt in bed [with] pad alarm in chair D/T [due to] subdural hematoma and inability to comprehend safety needs." On 12/10/10, the Restraint Assessment indicated: "Cont. [continue] roll belt when in bed [change] other restraints to least restrictive." "Less restrictive measures to be used: EZ release seat belt in w/c [wheelchair] [and] recliner instead of lap belt and chair pad alarm, floor mat alarm." There was no assessment to indicate a lap belt was used in the chair prior to this assessment.

The Restraint Assessment dated 1/28/11 indicated the following: "Cont. roll belt in bed. [Change] other restraints to less restrictive. Less restrictive measures to be used: EZ release seat belt in w/c cont. chair pad alarm in recliner, floor mat alarm. Additional Comments: Cont. to use

How will the corrective action be monitored to ensure the practice will not recur?

Random Quarterly physical restraint assessments will be monitored by the DON or the designee during the random weekly chart audit that we are currently performing on a minimum of 5 charts for indications of assessment prior to self releasing device use. Will report at the Performance Improvement Committee mtg. with the current P.I. Attachment C & E1

Systemic changes will be completed by March 5. 2011.

3/5/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155093	A. BUILDING _____ B. WING _____	02/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 272	Continued From page 11 1/2 top SR [siderails] to aid in bed mobility... Also added cushioned lap belt in w/c when anxious wanting to get up." The Care Plan, initiated 12/1/10, for potential for falls with a history of falls with head injury, and restraint use related to gets up on own, unable to remember to ask for assistance, included, but was not limited to, the following: "Provide least restrictive restraint as ordered." "Pad alarm in recliner." "EZ release belt while in chair [and] w/c." "2nd blue EZ release belt in the recliner." There was no assessment present for the use of a second easy release belt in the recliner, as of 2/2/11 at 2:00 p.m. On 2/3/11 at 10:15 a.m., RN #3 indicated Resident #9 had been assessed for the use of the current restraints and less restrictive devices on 2/2/11. She indicated therapy was not involved in the assessment. She indicated they assessed the resident by asking her to remove the two easy release belts, which she did on command. Other alternatives to the use of the two belts were not assessed. The Physical Restraint Elimination Assessment, completed on 2/2/11, was reviewed at that time. It indicated the action plan to continue the roll belt in bed and change other restraints to less restrictive. The less restrictive measures to be used were "EZ release seat belt in w/c and recliner; cont. chair pad alarm in recliner, floor mat alarm in front of chair or bed, cont. to use 1/2 top S.R. to aid in bed mobility [with] cues. Added 2nd blue EZ release belt in recliner [and] cushion lap belt while in w/c: Res. is able to release all belts on command and in front of nurse and	F 272		

3/5/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155093	A. BUILDING _____ B. WING _____	02/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 272	Continued From page 12 CNA." 3.1-31(a)	F 272		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based observation, interview, and record review, the facility failed to ensure treatment and services were provided to 2 of 7 sampled residents at risk for pressure sores and/or with pressure sores, in the sample of 11, to prevent pressure sores and/or to promote healing, prevent infection and prevent new sores from developing. The facility wound team was unaware of one resident who had pressure sores, and preventive measures were not used for one resident to prevent new sores from developing. (Residents #19, #14) Findings include: 1. During the initial tour of the facility, on 1/31/11 at 11:35 a.m., RN #2 indicated Resident #19 was recently admitted to hospice care. She indicated she had weight loss, incontinent of bowel and bladder, multiple sclerosis, diabetes mellitus, and a new diagnosis of cancer.	F 314	What corrective action will be accomplished for those affected by the deficient practice? For Resident #19: 1. MDS Coordinator did, in fact, meet with the Hospice nurse and stressed the importance of being notified of any new areas that she may find. She explained our process of documentation and how we are obligated to follow through for the resident , care planning, documentation on established forms, and hospice assured her this would occur in the future. Nursing staff was made aware of how this 1 resident, # 19, did not have the proper documentation on the established forms which would have alerted MDS Coordinator prior to resident going on hospice and would've enabled knowledge of the open area at an earlier date. When last assessed in December, her wound was healed. Rounds are completed weekly on those with open areas, and measurements obtained. 3/5/11	

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	155093	A. BUILDING _____ B. WING _____	02/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 13	F 314		

The clinical record was reviewed on 2/1/11 at 2:20 p.m. The physician had given a telephone order on 1/18/11 for a treatment change to the coccyx, "Discontinue Allevyn dressing to coccyx. Mepilex border dressing 4 X 5 cm [centimeters] square apply to coccyx after cleaning with wound cleanser. Do tx [treatment] Tuesday, Saturday and prn." The original treatment of Allevyn was ordered 12/17/10.
The medical record did not record any other information regarding the coccyx area.

The Hospice medical record was reviewed on 2/1/11 at 2:30 p.m. The resident was admitted to hospice on 1/12/11. The open area was first described on 1/17/11 by the hospice nurse, 0.1 X 0.2 X <0.1, no exudate, no odor and no inflammation. The hospice documented the area to the coccyx additionally on 1/24/11 0.3 X 0.2 X <0.1 and 1/31/11 0.3 X 0.4 X <0.1. Each measurement was larger than the last.

The "Norton Pressure Sore Risk Assessment" was completed on 1/12/11. The total score was 10; the score of 10-13 placed the resident at High Risk.

RN #3 was interviewed on 2/2/11 at 11:15 a.m. She was identified by the Administrator as the person in charge of the pressure ulcer/wound team. She indicated the resident did not have a pressure ulcer currently and presented a form which recorded a healed wound from December 2010. No other pressure ulcer records were available for the current wound being treated.

RN #3 indicated that she made skin rounds every Tuesday and the resident had not been seen

2. MDS error of 1/20/11 has had a correction submitted to indicate the area at the time of the assessment. 2/4/11

3. Facility has tried a low air loss mattress for this resident and she tolerated it for a very short time and requested that it be removed. She is very particular about her likes and dislikes and also often refused to turn or be repositioned. The record has this documentation but is not continually repeated. Her preferences have now been specifically indicated in the chart and on her care plan. The resident was at that time placed on the wound round list for weekly assessment of her open area/areas. Will be maintained on this list for continual follow up until healed, then be assessed weekly with full body assessment.

4. Hospice and a granddaughter convinced resident to try low air loss mattress again. Resident agreed with much hesitation and on

3/5/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155093	A. BUILDING _____ B. WING _____	02/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 14	F 314		

during the rounds since December 2010.

Resident #19's area was observed, on 2/2/11 at 11:20 a.m., with RN #4. The resident was positioned on her back with bilateral heels on the mattress with a small pillow between the feet. The resident was turned to her side, she was lying on a square waffle air cushion under her buttock area. The foam dressing was pulled to the side by RN #4. Two small areas at the coccyx area were observed. The skin around the open areas was dark pink in color. RN #4 indicated the resident had two areas to the coccyx. The foam dressing was replaced.

Prior to leaving the room, RN # 3 who was in charge of wound rounds and MDS assessments, entered the room. She asked RN #4 if the resident had open areas; RN #4 answered in the affirmative. RN #3 indicated she was unaware of the areas.

On 2/2/11 at 2:05 p.m., RN #3 indicated she had sent word to the hospice nurse to report to her if she found open areas on residents again. She indicated the resident had requested the waffle type cushion and that an low air loss mattress had been tried, and the resident had requested it be removed. RN # 3 indicated she was unaware of what type of mattress the resident was currently using on 2/2/11.

At 2:15 p.m. on 2/2/11, CNA #1 removed the sheet off the mattress to display the name of the mattress "Panacea Clinical." At 2:35 p.m. the Administrator received information online regarding what type of mattress the resident was using, indicating it was a pressure reducing mattress.

Feb. 11, 2011 , she insisted the mattress be removed and her Panacea Clinical mattress placed back on her bed. She also insists that a pillow be between her feet and that they not be floated. These preferences have been Care Planned and noted in her clinical record, after explaining the risks.

5. Resident will have a full body assessment weekly by the nurse. (NEW). Attachment A.

6. Braden Scale and interventions for her score have been added to her Care Plan.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?

All residents have been assessed with their care and have received a full body assessment within the past week by their nurse. Any areas found were to be documented according to policy. None were found.

2/20/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155093	A. BUILDING _____ B. WING _____	02/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIBSON GENERAL HOSPITAL-SNF	1808 SHERMAN DRIVE PRINCETON, IN 47670

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F 314	Continued From page 15	F 314		

The MDS [Minimum Data Set] quarterly assessment, dated 12/23/10, recorded the resident was "At Risk for developing pressure ulcers." The resident was identified as having an unhealed pressure ulcer, Stage 2, described as "Necrotic tissue (Eschar)." Interventions included on the assessment were "Skin and ulcer treatments application of nonsurgical dressings and applications of ointments/medications other than feet."

The newest MDS change of condition assessment, dated 1/20/11, recorded the resident was at risk for pressure ulcers, 0 [zero] current pressure ulcers, and no pressure ulcers present on the prior assessment.
"Skin and ulcer treatments" indicated "applications of ointments/medications other than to the feet."
The Braden Pressure ulcer assessment tool was dated 12/23/10 and 1/20/11; both recorded the total as 15. The form recorded "At Risk" 15-18.

The MDS Skin and Ulcer treatment area included "pressure reducing device for chair, pressuring reducing device for bed, turning/reposition program, nutrition or hydration intervention to mange skin problems, and ulcer care." None of those areas were marked for the resident in either assessment.

On 2/3/11 at 10:30 a.m., the Administrator, Director of Nurses and RN #3 discussed the above resident's care. RN #3 indicated the resident did not a have daily skin observation sheet or record on the skin assessment action sheet for the above open areas.

F 314

What measures will be put into place or what systemic changes will be made to ensure that the practice does not recur?

1. A schedule has been developed to assess each resident's body weekly by the nurse. Attachment B1 + B2
   Inservices 2/10/11 + 2/25/11
2. The completed assessments will be in the record for reference.
3. Assessment completion will be documented on the treatment sheet weekly. 2/20/11

F 314

How will the corrective action be monitored to ensure the practice will not recur?

Random body assessments will be monitored for completion by the DON or the designee with the random weekly chart audit that we are currently performing on a minimum of 5 charts. Any areas found on the assessments will be reviewed for proper documentation on established forms and proper follow through. Will report findings at the quarterly Performance Improvement Committee mtg. Attachment C + C1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155093	A. BUILDING _____ B. WING _____	02/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 16			

RN #3 indicated she reviewed the clinical records when completing the MDS assessments, "I just missed that...." She indicated the MDS assessment was coded wrong.

On 2/3/11 at 9:00 a.m., the policy for "Management of skin integrity and wound prevention" was provided by the Administrator.

The purpose was as follows: "The purpose is to be proactive in the prevention of skin breakdown for all residents while in our facility." The Procedure included the use of Daily Skin Observation Sheet which was to be used by any member of nursing staff who finds a break in the skin. Skin Assessment Action sheet was a prompt used for proper completion of required action with any break in skin integrity.

2. During the initial tour, on 1/31/11 at 11:40 a.m., RN #2 indicated Resident #14 was dependent for care due to weakness. She indicated the resident had weeping edema of the lower legs, with open areas on the right lower leg and on the left leg just above the knee. She also indicated the resident had an open area on the coccyx.

Resident #14's clinical record was reviewed on 1/31/11 at 3:25 p.m. The resident was admitted to the facility on 1/10/11 with diagnoses including, but not limited to, shortness of breath, pulmonary fibrosis, type II diabetes mellitus, chronic obstructive pulmonary disease, recurrent urinary tract infections, and peripheral vascular disease.

On 2/1/11 at 11:50 a.m., Resident #14 was observed to be in bed, positioned on her right side. One pillow was under her legs, yet the feet

F 314 Continued For Resident # 14:

What corrective action will be accomplished for those affected by the deficient practice?

This resident had pillows provided during the survey for placement of heels upon pillows. DON and nurse #3 did round frequently to ensure heels were floated at that time and daily following survey. Heel protectors were applied as indicated on 2/2/2011. Her Braden Scale score and risk for breakdown was care planned with interventions.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?

1. Braden Scale scores were reviewed and care planned on all residents.

2. During the week of survey, 24 waffle cushions were ordered for resident use in their wheelchair seats or bedside chairs. Some residents do have their own cushions and some that are up and about during the day may not want a cushion, but will have one available if they so choose. They arrived the week following survey and have been placed as indicated. 2/9/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155093	A. BUILDING _____ B. WING _____	02/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 17	F 314		

were still resting on the bed. The resident complained of sore heels.
The resident was observed in bed with her heels resting on the mattress, on 2/2/11 at 10:50 a.m. No pillow was present.

On 2/2/11 at 11:15 a.m., Resident #14's heels were observed with RN #4. The right heel had a dark red triangular area, 1 centimeter in diameter. There was redness surrounding the darker area, 3-4 centimeters around the area. The left heel was dark pink in color. RN #4 indicated the heels needed to be elevated and got a pillow and elevated the heels. The resident had an irregular shaped open area on the coccyx, with yellow slough, less than one centimeter in diameter. At 11:20 a.m., RN #4 indicated she had instructed the CNAs to get more pillows.

On 2/2/11 at 11:30 a.m., the wound records were reviewed. On 1/25/11, a coccyx area was documented. The record indicated it was a stage II area [partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough. May also present as an intact or open/ruptured serum filled blister]. The area measured 3 centimeters [cm] long, 1 cm wide, less than .1 cm deep. Comments indicated, "(slit) Red floor [no] drg [drainage] with light red area surrounding, Allevyn adhesive." On 2/1/11, the area was identified as a stage III [full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling].

A wound sheet was also completed, on 2/1/11, for the right lateral heel. It was identified as

3. 5 sets of Heelift boots were ordered the week of survey, as well. These also came in the next week and several pairs have been utilized as indicated for floating heels where a pillow might not have been the device of choice. 2/9/11

4. Additional pillows were obtained for positioning and floating heels. 2/3/11

5. MDS coordinator and DON evaluated all residents for pressure relief needs and provided pillows, cushions, or heel protectors as needed. 2/4/11

Inservices 2/10/11 + 2/25/11.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155093	A. BUILDING _____ B. WING _____	02/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 18	F 314		

unstageable [full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the ulcer bed]. The dimensions were 2 cm long by 2.3 cm wide. The depth was identified as .3 by .3. The response to treatment/comments indicated, "unstageable, moderate redness 4.2 X 6 - off load."

A Braden Assessment for risk of pressure sores was completed on 1/14/11. The resident's score was 17, indicating the resident was at risk for pressure sores. The Protocols by Risk Level from the Braden Scale, dated 2001, indicated the following for residents at risk: frequent turning, maximal remobilization, protect heels, manage moisture, nutrition, and friction and shear, and pressure-reduction support surface if bed or chair bound.

Care plans included, but were not limited to, the following:
1/25/11 Top of coccyx - slit, area will be healed by next review, 1) txmt [treatment] as ordered [and] monitor effectiveness. 2) Assess wkly [weekly] [and] chart. 3) Notify MD PRN [as needed]
2/1/11 Stg [stage] III on coccyx decline in condition, area will be healed by next review, 1) txmt as ordered. 2) Enc [encourage] to try [and] eat meals [and] drink her fluids at meals [and] in between. 3) alternating mattress. 4) Air cushion in chair. 5) Notify MD PRN. 6) T/R [turn/reposition] side/side Q [every] 2 [hours] and PRN. 7) Heels off surface of bed.

Interventions to protect the heels were not included until after the area developed.

A physician's order, dated 2/2/11 at 9:31 a.m., indicated "Heel protectors to bilat [bilateral] heels

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?

1. All residents have had their Braden scale scores care planned, with interventions in place the week following survey. 2/11/11
2. All new admits will be provided an extra pillow for floating heels and a waffle cushion for their wheelchair for time up in a wheelchair or chair as indicated.
3. A turning schedule has been implemented and is routinely checked for compliance by DON and/or MDS coordinator. Attachment D. 2/15/11
4. Weekly skin assessments by the nurse have been implemented and are currently being documented on the treatment sheet with any follow up as indicated. Attachment A. 2/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155093	A. BUILDING _____ B. WING _____	02/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 19 to prevent sores while in bed." RN #3 was interviewed, on 2/2/11 at 2:35 p.m. She indicated, "I know they [the heels] were floated last week because I did it. Usually they are pretty good. This week I can't vouch for them." At 3:30 p.m., RN #3 and the Director of Nursing indicated RN #3 made rounds to check for feet up on pillows. RN #3 provided documentation of supportive device placement checks, on 2/3/11 at 10:05 a.m. On 1/25/11, the documentation indicated the following for Resident #14: "reposition heels pillows." On 1/31/11 for Resident #14, she indicated "moves self," no indication of floating the heels. 3.1-40(a)(1) 3.1-40(a)(2)	F 314	How the corrective action will be monitored to ensure the deficient practice will not recur? Random body assessments will be monitored for completion by the DON or the designee with the random weekly chart audit that we are currently performing on a minimum of 5 charts Any areas found on the assessments will be reviewed for proper documentation on established forms and proper follow through. Will report findings at the quarterly Performance Improvement Committee mtg. Attachment C + C1 Systemic changes will be completed by March 5. 2011	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure it was free of a medication error rate of 5 percent or greater. The facility failed to provide residents their medication as ordered by the physicians to be given with supper and/or food, for 1 of 9 sampled residents (#13), in the sample of 11, and for 1 of 13 supplemental sample (#7) residents, in the supplemental sample of 13. Forty-three [43] opportunities for	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155093	A. BUILDING _____ B. WING _____	02/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIBSON GENERAL HOSPITAL-SNF	1808 SHERMAN DRIVE PRINCETON, IN 47670

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F 332	Continued From page 20	F 332		

error were observed, with 4 errors, resulting in an error rate of 9.3 %.

Findings include:

1. Resident #7 was observed, on 2/1/11 at 4:35 p.m., to receive her medications from LPN # 1. The resident received her medication in one spoon full of applesauce.
Zocor 20 mg one tablet given, label instructions were "with supper"
Metformin 500 mg two tablets given, label instructions were " twice daily with food"
Zetia 10 mg one tablet given, label instructions "with supper"

The resident was observed to receive her supper tray at 5:05 p.m. on 2/1/11.

On 2/2/11 at 9:50 a.m., the medical record of resident #7 was reviewed. The physician's signed orders were dated 11/5/10. "Zocor [Simvastatin] [for lowering cholesterol] 20 mg one tablet oral daily w/ [with] supper, order date 6/2/10."
"Glucophage ER [Metformin] 2 tabs of 500 mg at 0800 [8:00 a.m.] and 17:45 [5:45 p.m.] regardless of intake but do give with food, order date 2/9/10." for treatment of diabetes mellitus.
"Zetia 10 mg [for lowering cholesterol] one tablet oral daily w/supper, order date 7/17/09."

2. Resident #13 was observed at 4:55 p.m. to receive her medications from LPN #1 on 2/1/11. The resident received Niferex Forte [Ferrex] 150 mg [Iron Supplement] one tablet given, label instructions were "one every day with food." The resident's supper tray was served at 5:15 p.m.

What corrective action will be accomplished for those residents found to have been affected by the deficient practice?
Resident #7 and #13's medications have been reviewed and DON met with the nurse to counsel regarding medication pass requirements for correct administration. Those medications indicated for administration with food or meal are being given as directed.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?

1. All resident's medications have been reviewed for those required to be given with meals or food.
2. Although noted on the MAR's, a separate listing of resident's meds that are to be given with food or meals has been provided for easy reference and reminders.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice doe not recur?

1. Re-training has been provided to nursing staff to reinforce correct medication pass procedures.
2. Whole individual serving size containers (4 oz) of applesauce are available at each nursing station for those instances where medication can not be given with a meal. Food items are also available in the pantry should there be a need for food items to be given with meds in the night.

How the corrective action will be monitored to ensure the deficient practice will not recur:

A random med pass will be monitored 1x weekly for 5 residents to observe compliance of meds given with food or meals.

Findings will be evaluated and reported Qrtly to the Performance Improvement Committee. Attachment E + E1.

Systemic changes will be completed by March 5, 2011.

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F 332	Continued From page 21 On 2/2/11 at 10:00 a.m., the medical record for resident #13 was reviewed. The Niferex Forte was ordered 8/20/10 "one tablet oral daily w/supper." Given as an iron supplement for the resident. The physician last recapped orders were signed 1/29/11. 3.1-25(b)(9) 3.1-48(c)(1)	F 332		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their		F 441 What corrective action shall be accomplished for those residents found to have been affected by the deficient practice? As we cannot undo that day, we go forward to note that this resident's caregivers decontaminate hands based on guidelines for hand hygiene and gloving as recommended by CDC's Standard Precautions. All wipes in her room were discarded, RN did wash hands in soiled utility room, guidance/inservicing given to nurse. 2/3+2/4/11 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. 1. All residents have the potential to be affected by any practice that is not the correct use of Standard Precautions, decontamination and gloving practices. 2. Gloves are in all rooms, as well as alcohol-based hand rubs, soap dispensers, and disposable towellets for drying hands. 3. Staff has been re-inserviced on hand hygiene. 4. Procedure for using bath wipes has been reviewed with all staff to reinforce removing the wipes they will need prior to starting procedure.	

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F 441	Continued From page 22	F 441		

hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on record review, observation and interview, the facility failed to provide infection control techniques for each resident in that handwashing was not completed during the observation of treatment and incontinence care for 1 of 5 sampled incontinent residents observed in a sample of 11. (Resident #29)

Finding includes:

Resident #29 was observed, on 2/2/11 at 2:45 p.m., to receive treatment to a pressure ulcer on the coccyx. RN #3 and CNA #2 assisted the resident to turn/position self during the treatment. The resident indicated that her catheter was being clamped and drained every three hours on that date. While being turned, the resident loudly stated, "Oh no my urine, check to see if feces came out too." RN #3 did check the resident, who had a feces smear.

During the observed incontinent care, the CNA left the room to retrieve linens. RN #3 wore gloves and used the resident's wet wipes to clean the incontinent feces. The RN reached in the plastic container of wet wipes three times with the

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?

The Handwashing policy and procedure has been reviewed and revised (Attachment F(5)) to clarify the *CDC Guideline for Hand Hygiene in Health-Care Settings* in the attachment provided. It notes that decontaminating hands with alcohol based hand rub is appropriate "after removing gloves". Attachment G(2) Staff has also been inserviced as a refresher to know that cross-contamination will occur with soiled gloves moving into what is considered a clean area, i.e. the wipes noted during the dressing change with subsequent peri-care.

How will the corrective action be monitored to ensure practice will not recur?

DON or designee currently monitors a minimum of 20 handwashing opportunities each month. Will add the observation of proper use of alcohol based hand sanitizers/gels/hand rubs for decontamination to the current form and report findings quarterly at the Performance Improvement Committee meeting.
Attachment H

Systemic changes will be complete by 3/5/11.

3/5/11

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F 441	Continued From page 23 soiled gloves. RN #3 then left the room to get more gloves. The CNA and RN both left the room one time; both used the alcohol gel to cleanse their hands. At the end of the treatment and incontinent care, soiled linens and trash were removed from the room; the CNA and RN used the alcohol gel to cleanse their hands prior to leaving the room. The policy "Guidelines for Hand Hygiene Policy and Procedure" was provided on 2/3/11 at 9 a.m. by the Administrator. The policy was effective 9/2/2004 and revised 1/2009. Recommendations for handwashing "Decontaminate hands after removing gloves." Item 10. "Gloves are not intended to be a substitute for handwashing. Hands shall be washed immediately and thoroughly after gloves have been removed." On 2/3/11 at 10:30 a.m., the Administrator, Director of Nurses and RN #3 were informed of the above observations during the treatment and incontinence care of the resident. RN #3 stated "Ok." 3.1-18(l)	F 441	Inservices held to address all Tags 2/10/11 & 2/25/11. Facility Services 2/22/11	3/5/11